Chapter XI: View Patient Information

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Patient Information Tab Overview

Documentation entered in the **Patient Information Tab** is used as a tool to communicate information with multiple departments. This function is also used to view, enter and edit information. There are five data entry options available to you. See **Chapter 12** for details on how to enter patient information for these categories.

- Allergies
- Comments
- Care Provider
- Significant Event
- Height/Weight

Additional data displays that interfaces with the **Admission, Discharge and Transfer** (ADT) system. These include:

- Health Issues
- Address/Phones/Contacts
- Demographics/Visit
- Financial/Employer
- Visit History

Note: Any changes to this data should be communicated to the Admissions/Registration department.

Summary View Descriptions

Summary View Description	Information Displayed
Alerts	Displays acknowledged and unacknowledged alerts for the selected patient. You can select details to view more information.
Allergies/Comments	Top portion of the window displays allergies documented for a patient. The bottom portion of the window displays both interfaced and entered data. Interfaced data includes: chief complaint, citizen information, mother and father's name, occupation, patient's maiden name. Data to be entered includes: advance directive information, interpreter, prosthesis, other, protocol appointments, special needs, VAD line history and local contact information.

Summary View Description	Information Displayed
Care Providers	Displays all physicians/providers directly related to the care of a patient (i.e. Admitting Physician, Ordering Physician, Consultant)
Health Issues	Displays the patient protocol(s) information received from the ADT system. Protocol information is confirmed and updated by the Medical Records Department staff.
Significant Events	Displays consents, isolation status, transfusion history, immunization history and tracheostomy.
Address/Phones/Contacts	Displays interfaced addresses, phone numbers and emergency contact data from the ADT system.
Demographics/Visit Data	Displays patient's address and visit data information interfaced from the ADT system.
Financial Employer	No data will be displayed.
Visit History	Displays history of visits (past and present) for a patient from the ADT system.

Table 11.1: Patient Info Summary Views

Scope of Data Entered

Some data entered will carry across all patient visits and will not need to be re-entered. This information has a scope of **General** which means data from prior patient visits and the current patient visit will be available in this view. For example, in the Patient Info Tab Comments option, Prosthesis, Special Needs, Protocol Appts, and VAD Line Hx have a scope of **General**.

Some data entered will be limited to the current visit and will need to be re-entered each time the patient returns to NIH. This information has a scope of **This Chart**. For example, in the Patient Info Tab Comments option, Advance Directives, Interpreter and Other have a scope of **This Chart**.

You can also view entered data for this visit (This Chart) versus all visits (All Available) in the **Documents** and **Flowsheets** Tab by changing the filter.

- Charts will remain open (available for you to enter data) for 60 days after inpatient discharge
- Charts will remain open (available for you to enter data) for 90 days for deceased patients.

View Patient Information

The **Patient Info** chart section contains functions to help you view, edit, add, delete, or discontinue patient information related to demographics, visits and visit history, allergies, health issues, patient contacts, address and telephone numbers, discharge dates, height and weight, care providers, comments, and significant events.

Patient information can enter CRIS in one of two ways:
- From an interface to an admitting system (ADT).
- Directly, using CRIS.

To display the **Patient Info** chart section, click the **Patient Info** tab, or from the **GoTo** menu, select **Chart Section**, then **Patient Info**.
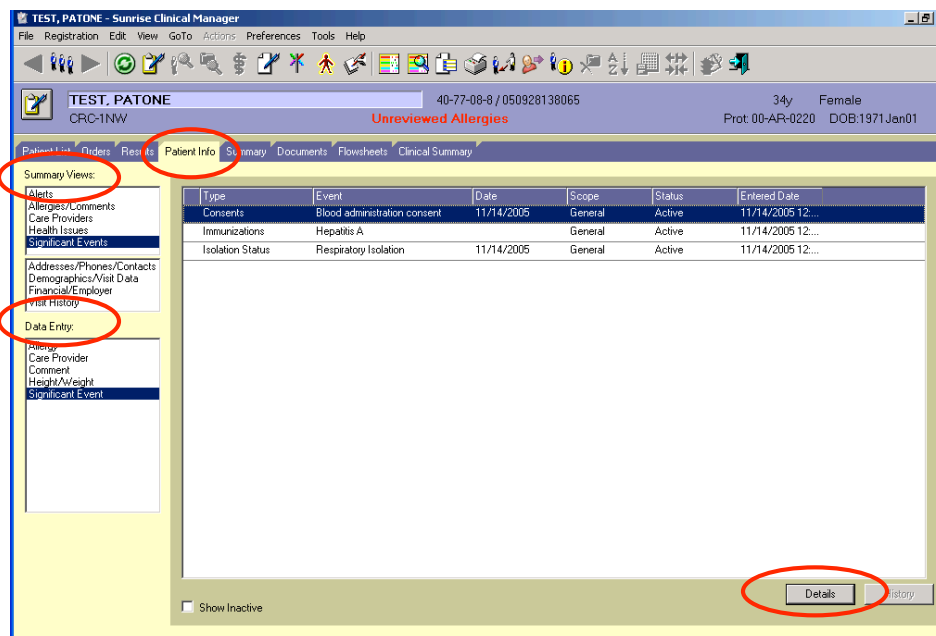
Screen 11.1: Patient Info tab

The **Patient Info** chart section contains a list of **Summary Views** located in the upper left corner of the tab. You can click on a **Summary View** option to display patient information related to that topic. If you want more detailed information or want to change the information, you can select an item in a **Summary View** and click **Details**. You can click on one of the **Data Entry** options to view or change patient information (see Chapter 12 for details)

View Alerts

You can display **Alerts** for the selected patient by clicking on the **Alerts** option in the **Summary View** in the **Patient Info** chart section.

Alerts are messages displayed to users to provide guidance and/or options related to some action they are about to perform. For example, if a physician starts to order a medication that the patient may be allergic to (based on active allergies entered into CRIS), a message appears to inform the user of this allergy so they can take the appropriate action. Anytime a drug interaction message fires this will be noted under the **Alert** option of the **Summary View**.

Screen 11.2: Alerts Summary View

Allergies and Comments

The top half of the **Allergies/Comments** summary view displays all active allergies that have been entered for the patient.

An icon ( ) in front of the **Reaction** column indicates that there is additional information to view about the allergy.

Screen 11.3: Information Icon on Patient Info Tab

The bottom half of the **Allergies/Comments** summary view displays all active comments that have been entered for the patient.

Screen 11.4: Allergies/Comments Window

Allergies are considered general in scope, meaning that they will display in any chart and across all visits for the patient.

If an allergy or comment has been changed, an icon displays when you display the **Allergies/Comments** section in the **Patient Info** chart section. You can select the allergy or comment and click **History** to open the **Modification History** dialog box.
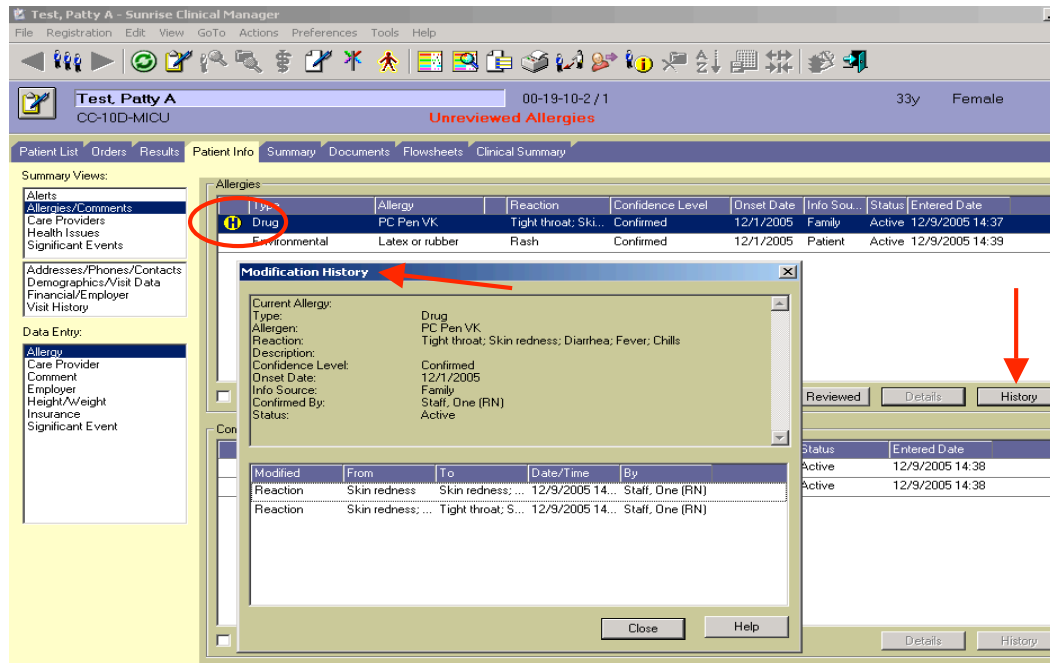


Screen 11.5: History icon

View an Allergy

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. View or change information about the allergy in the **Allergy Details** dialog box.
4. Click **OK**.

View Allergy History Information

1. From the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Select an allergy, and click **Review History**. The **Allergy Review History** dialog box opens.
3. Review the information and click **Close**.

Mark Allergy as Reviewed

The patient header displays **Unreviewed Allergies** in bold red font if allergies have not been reviewed for this visit. Since allergy information is **General** in scope and crosses all visits, it is not necessary to reenter this information everytime a patient is admitted (inpatient or outpatient). However, it is important that each time the patient is seen is that allergy information is reviewed and/or updated for accuracy. This information can be recorded in CRIS by marking the allergies as reviewed.
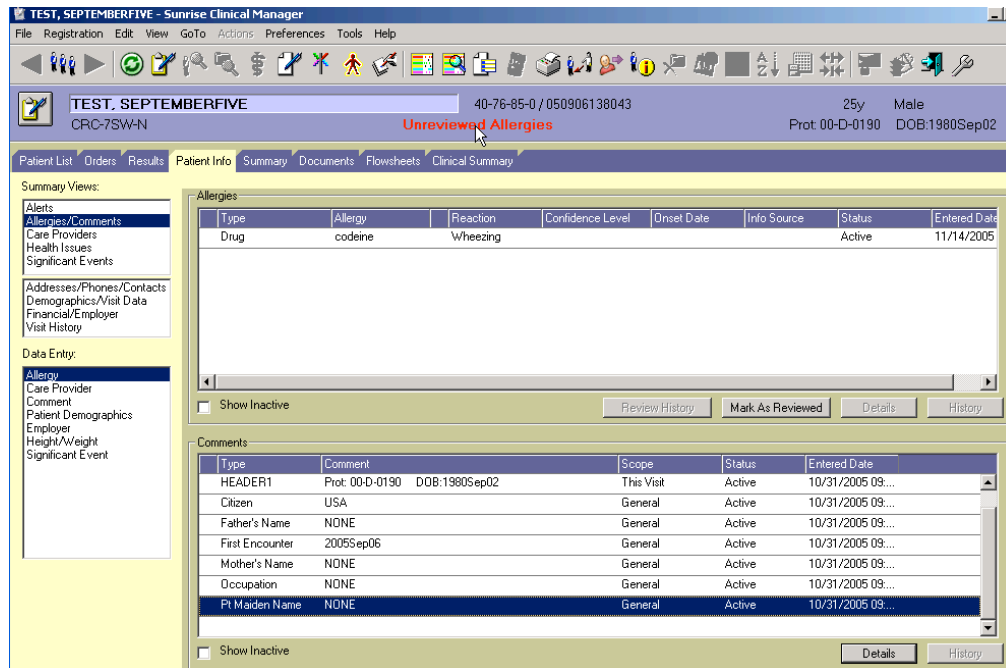
Screen 11.6: Unreviewed Allergies

1. In the Patient Info tab, select **Allergies/Comments** from the **Summary Views** list.
2. Select an allergy and click **Mark as Reviewed**.
3. The Unreviewed Allergies alert no longer displays.

Screen 11.7: Allergies – Mark as Reviewed

Maintain Allergy Information

Once new allergies are entered, information should be maintained. Actions that may be taken on existing allergies include: edit, discontinue, reinstate, or delete. Your job description and security rights determine if you can perform these actions. See **Chapter 12** for details on how to add and change allergy information.

View a Comment

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click a comment, or select a comment and click **Details**. The **Comment Details** dialog box opens.
3. View or change the comment in the **Comment Details** dialog box.
4. Click **OK**.

Maintain Comment Information

Once new comments are entered, information should be maintained. Actions that may be take on existing comments include: edit, discontinue, or delete. Your job description and security rights determine if you can perform these actions. See **Chapter 12** for details on how to add and change comment information.

View Care Provider Information

You can display care providers by clicking on the **Care Providers** summary view in the **Patient Info** chart section. Some care provider information crosses over from the Admission, Discharge, and Transfer (ADT) system. Other care providers can add their names when appropriate.
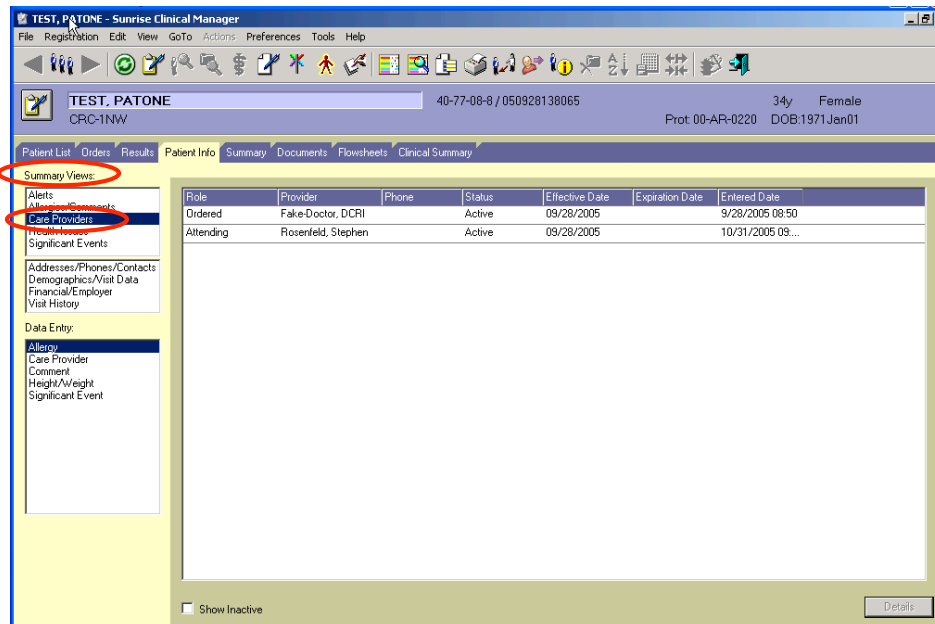

Screen 11.8: Care Providers Summary View

Maintain Care Provider Information

Once new care provider information has been entered, this information should be maintained. Actions that may be taken on existing care provider information include: discontinue or delete. Your job description and security rights determine if you can perform these actions. See **Chapter 12** on how to add and maintain care provider information.

View Health Issues

You can display health issues sorted by status and type, by clicking on the **Health Issues** summary view in the **Patient Info** chart section. Currently, the Protocol number and information is what appears in the Health Issues view.

If a Health Issue has been changed, an icon () displays next to the item.
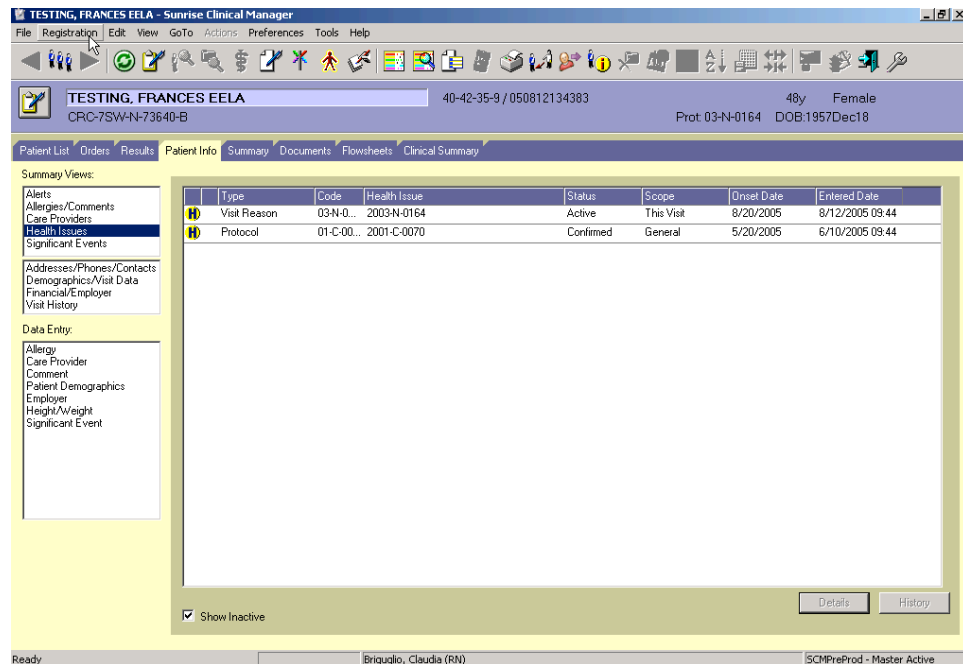
Screen 11.9: Health Issues Summary View

You can select the health issue or protocol and click **History** to open the **Modification History** dialog box.
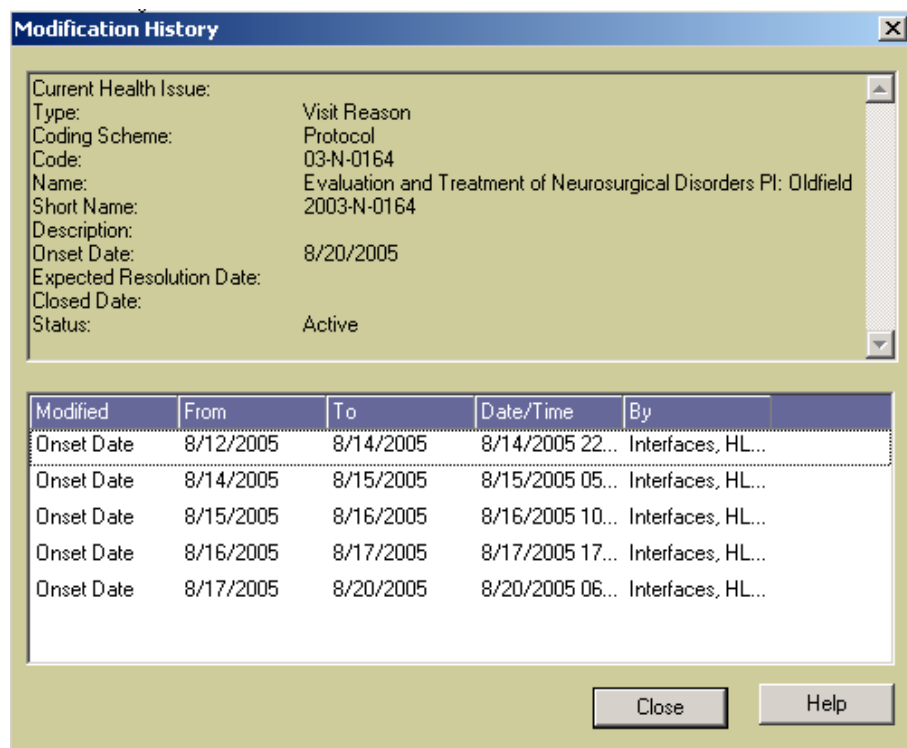
Screen 11.10: Health Issues Modification History window

You can select the health issue or protocol and click **Details** to open the **Health Issues Details** dialog box.

Screen 11.11: Health Issues Details window

Maintain Health Issues

Protocol information under the Health Issues summary view is maintained by the Medical Records Department. See **Chapter 16** for Protocol Management process.

View Significant Event Information

You can display a list of the patient's significant events such as Immunization History or Isolation Status by clicking on the **Significant Events** summary view in the **Patient Info** chart section.

If a significant event has been changed, an icon (🅗) displays next to the item.

You can select the significant event and click **History** to open the **Modification History** dialog box.
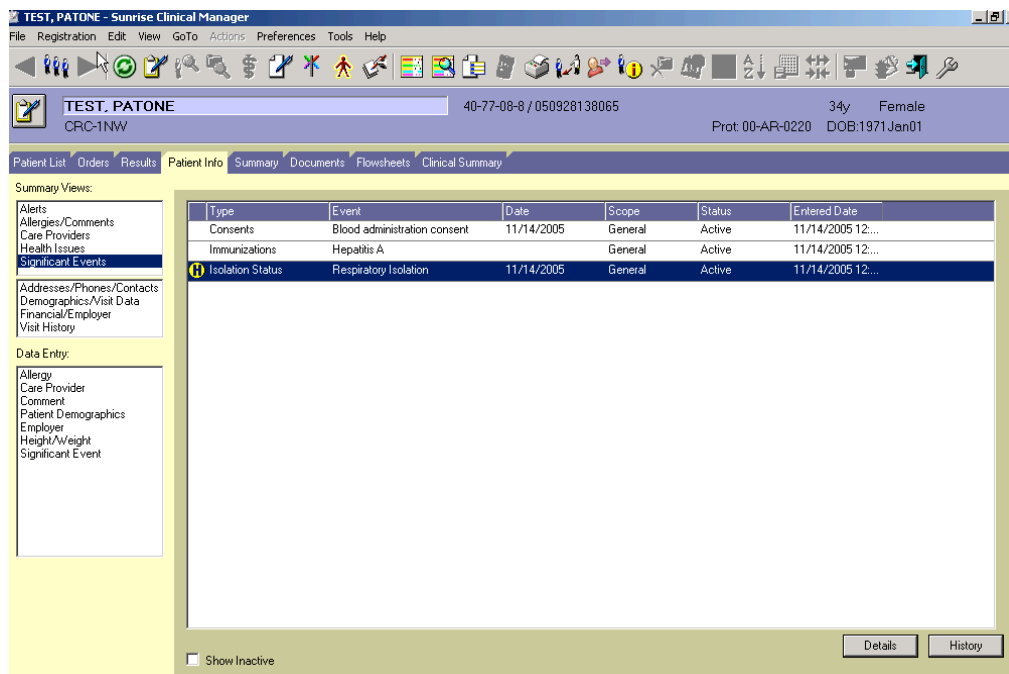
Screen 11.12: Significant Events Summary View

Maintain Significant Events Information

Once new significant event information has been entered, this information should be maintained. Actions that may be taken on existing significant event information include: discontinue, edit or delete. Your job description and security rights determine if you can perform these actions. See **Chapter 12** for details on how to add and change significant event information.

View Addresses, Phone Numbers and Contact Information

The top part of the **Addresses/Phones/Contacts** summary view displays the patient's addresses.

The middle part of the **Addresses/Phones/Contacts** summary view displays the patient's phone numbers.

The bottom part of the **Addresses/Phones/Contacts** summary view displays the patient's contacts.

Screen 31.13: Address, Phone and Contacts Summary View

Maintain Patient Address, Phone, and Contact Information

Contact the Admissions Department to update address or phone information.

View Demographic and Visit Data Information

The top half of the **Demographics/Visit Data** summary view displays demographic information about the patient, including the patient's age, gender, marital status, primary language, birth date, religion, and race.

The bottom half of the **Demographics/Visit Data** summary view displays information about the patient's visit data, including length of stay, admit date and time, and discharge information.

Screen 4.14: Demographics & Visit Data Summary View

Maintain Demographics/Visit Data

Contact the Admissions Department to update demographics and visit data.

View Visit History Information

You can display information on the patient's visit history by clicking on the **Visit History** summary view in the **Patient Info** chart section. You can click **Details** to view the details of a visit.

Screen 51.15: Visit History Summary View

Filter Visit History

The filter button allows you to filter the type of visits you would like displayed in the **Visit History**. The **Visit History Filter** window provides a list of items to select from to filter. Once the filter is applied the **Not Filtered** message on the lower left changes to **Filtered**.
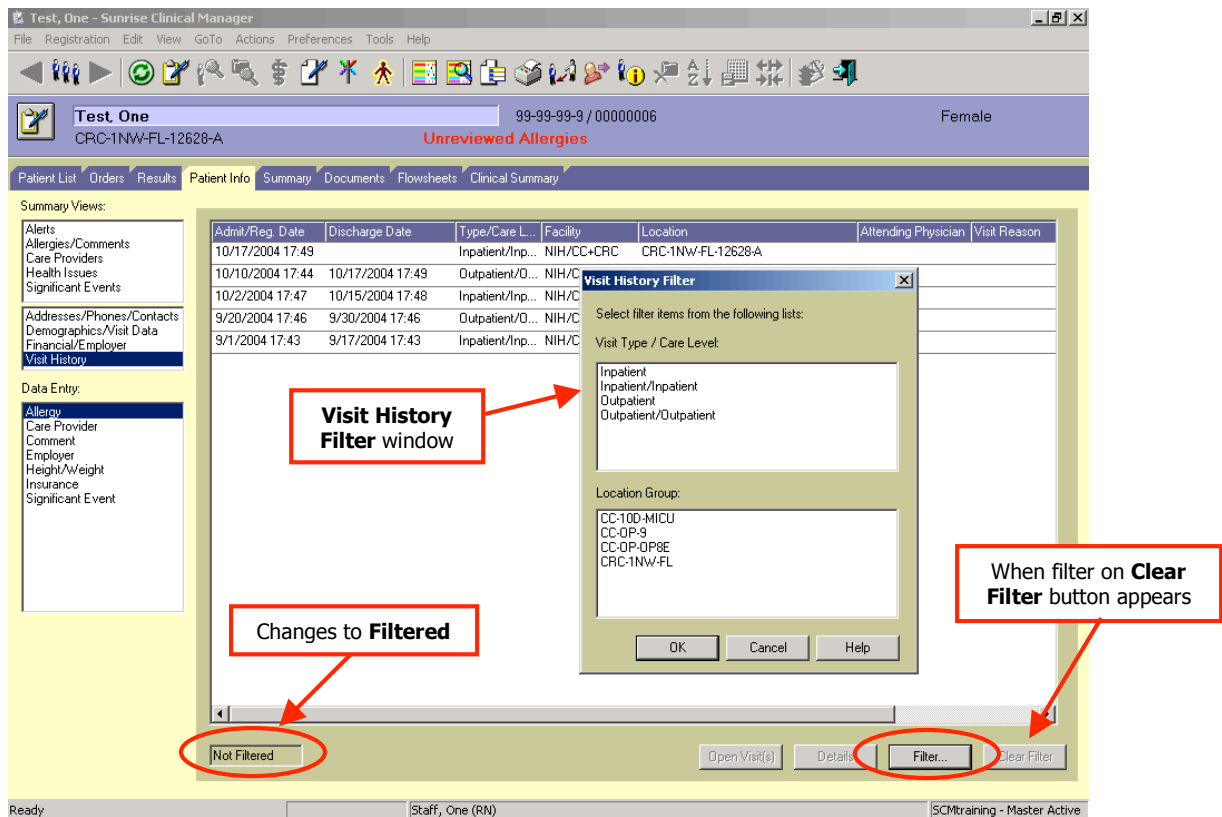
Screen 61.16: Visit History Filter

Unfilter Visit History

To unfilter the visit history information click on the Clear Filter button on the bottom left of the screen.

Maintain Visit History information

The Admissions Department assumes responsibility for updating Visit History information.

The Summary Tab

The **Summary** tab provides a quick overview of selected patient information. This information can be useful if you are seeing a patient for the first time, or are becoming familiar with your patient assignment.

Screen 71.17: Summary Tab

View and Edit Data in the Summary Panels

1. To expand the view of data in a summary panel click the Expand button .
    The Summary dialog box for that panel opens, displaying active and inactive
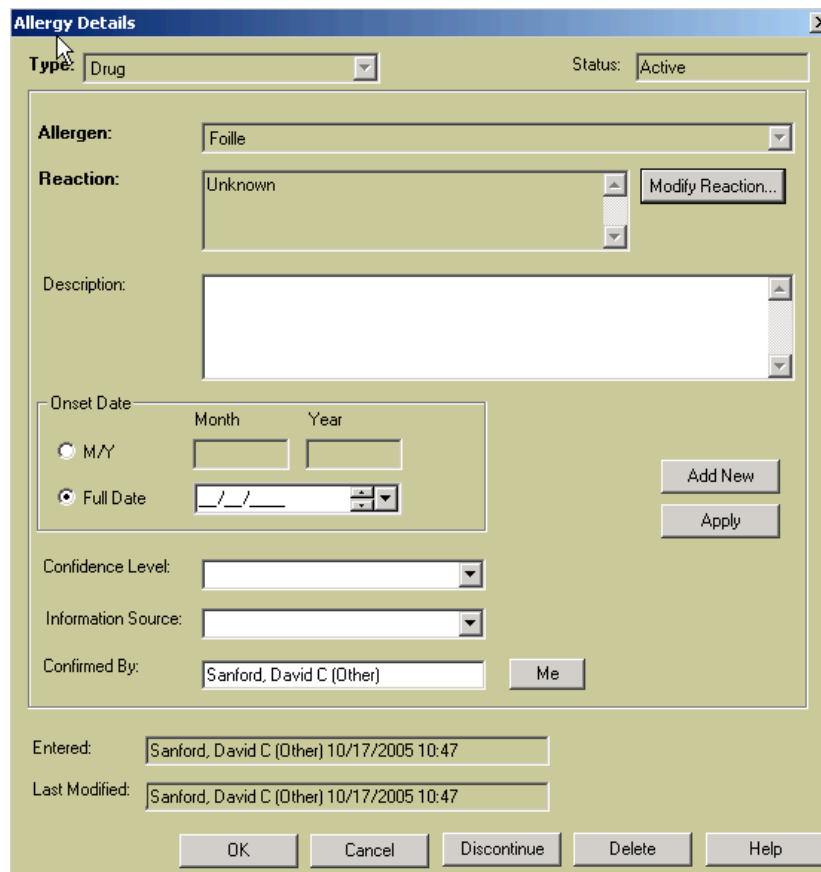   information.

Screen 11.18: Allergies Summary dialog box

2. To view the detail of an item, select the item you want and click **Details**.
    The Details dialog box for that panel displays.

Screen 11.19: Allergies Details dialog box

If security rights permit you to edit information, this can be done by following steps 1 and 2 then go ahead and

3. Edit the information.
4. Click OK.
5. Click Close.